STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00			ETED
						08/21/	2013
			B. WIN			00/21/	2010
NAME OF P	ROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	NO VIDEN ON SOLVEIE			449 MA	IN ST		
VERMILL	JON PLACE			ANDER	RSON, IN 46016		
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES		ID	Г		(V5)
					PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
R000000							
	This visit was f	for the Investigation of	R00	00000	This is the plan of correction for	or	
		0134810, IN00134755			this complaint survey.		
	and IN0013483						
		30.					
	_						
	Complaint IN0	0134810:					
	Substantiated	at R0041, R0090, and					
	R0187.	, , , , , ,					
	1.0107.						
	0 1 1 1 11 10	0.4.0.4.7.7.7					
	Complaint IN00134755: Substantiated at R0041, R0090, and						
	R0187.						
	Complaint INIO	0124926:					
	Complaint IN0						
	Substantiated	at R0041, R0090 and					
	R0187.						
	Survoy data: /	August 21, 2013					
	Survey date. F	August 21, 2013					
	Facility numbe	r: 011970					
	Provider numb	er: 011970					
	AIM number: I	N/A					
		•					
	Cumios Tagina						
	Survey Team:						
	Shelley Reed,	RN TC					
	Census bed ty	pe:					
	Residential: 4	•					
		O					
	Total: 40						
	Census payor	type:					
	Other: 40						
	Total: 40						
	10tai. 40						
					l		
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 14 State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet

PRINTED: 10/18/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING  B. WING	00	COMPLETED 08/21/2013			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-			
	ION PLACE		449 MAIN ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Sample: 3							
	accordance wit	dings are cited in h 410 IAC 16.2. completed by Debora						

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 2 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION 00	(X3) DATE S COMPL	ETED
			B. WING			08/21/	2013
	ROVIDER OR SUPPLIER		4	49 MAI	DDRESS, CITY, STATE, ZIP CODE N ST SON, IN 46016		
(X4) ID PREFIX	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	PRI	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	Т	AG	DEFICIENCY)		DATE
R000041	policies for invest complaints when grievances made (A) an individual r (B) a resident couboth; (C) a family memi (D) family groups (E) other individual Based on obse and interview, the acknowledge gresidents in restand failed to acknowledge gresidents living.  Findings included 1. During an interestant of 3 with the start of 3 with facility was made by residents were waiting or fix the problem shower days with show	- Deficiency all develop and implement igating and responding to made known and by: esident; encil or family council, or oer; e or als. rvation, record review the facility failed to rievances made by eident council meetings etively attempt to evance. This deficiency residents interviewed ble water Resident C, D and E), mpacted 40 of 40 in the facility.	R0000	041	R041Residents C, D and E-Th parts the facility were waiting for arrived on August 27 and the five water was fixed that day. This repair was completed for all residents of the facility. The maintenance department will monitor the water temps of the building on a regular basis. Anoted in the survey notes, residents were provided information in the Resident Council on the progress. As information was received from corporate office and vendor, the information was passed on to residents. The policy for investigation of and responding complaints is below. This policis maintained by the administra and/or his/her designee. The investigations, summaries of Resident Council, and concern logs will be monitored by the C.E.O. of United Faith Housing Corporation. The review will taplace monthly for 6 months, ar then quarterly thereafter. The repairs were completed by 8/30/13. The systematic changes.	or not sis the ne the the cy nator	10/11/2013

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 3 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00		00	COMPLETED	
			B. WIN			08/21/	2013
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
\/EDMILI	JON PLACE			449 MA			
VERIVIILI	LION PLACE			ANDER	RSON, IN 46016		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	only washing ເ	ip with heated water			where put into place by 9/26/1		
	from the micro	wave.			TITLE: RESIDENT COMPLAI	NT	
					AND RESOLUTION		
	2 During an ir	nterview on 8/2/13 at			PROGRAM It is the policy of the		
	_				facility to address complaints a		
	· ·	esident #D indicated			concerns when made known a		
		refusing showers			grievances made by: In individual residentA resident council or	uual	
	because of the				family council, or bothA family		
	temperature.	She indicated the			memberFamily groupsOther		
	problem had b	een going on for			individuals The means of		
approximately 2 weeks. She					investigating and resolving		
	indicated she had been heating water				complaints and concerns		
					depends on the nature of the		
	up in the microwave and using it to				complaint or concern. The		
	wash up.				Administrator or his/her desigr		
					meets with residents on a wee	kly	
	_	nterview 8/21/13 at			basis.Residents may voice		
	2:00 p.m., Res	ident #E indicated she			concerns which might affect th		
	had been takin	g cold showers related			group at large.A summary of the	ne	
	to the lack of h	ot water. She			items discussed at these meetings is maintained in the		
		nad also been heating			Administrator's office and		
		icrowave to wash up			available for review by resider	ıts.	
	with.	icrowave to wash up			families and staff. Food conce		
	WILLI.				are given to the Food Service		
					Supervisor and logged in the		
	_	servation on 8/21/13 at			Food Service Department.		
	2:20 p.m., the	Assistant Maintenance			Concerns from individuals may		
	Director was a	sked to check random			brought to any staff member a		
	water tempera	tures in several rooms.			any time.Concerns will be logg	ged	
	Room 113 had	l a water temperature			by the Administrator and	m <sup>1</sup> C	
		s, room 220 had a			maintained in the Administrato office. The concern log will also		
	_				note the resolution to the cond		
	water temperature of 96.8 degrees and room 229 had a water				and any follow up required.An		
					concerns related to the physic		
	i temperature of	f 92.6 degrees.			plant of the facility will be turned		
					in to the Maintenance departm		
	During review	of resident council			or C.E.O. of United Faith Hous	sing	
	minutes, dated	l 8/14/13 and 8/21/13,			as indicated. Any complaint w		
	residents voice	ed concerns related to			involves the suspicion of abus	e or	
	I		1		i		I

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 4 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		INSTRUCTION 00	(X3) DATE COMPL		
THIE TEXT	or condition	IDENTIFICATION NOMBER.	A. BUILDING			08/21/	
			B. WING	EET A	DDDESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
VERMILI	ION PLACE				SON, IN 46016		
				DLIN			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG			IAC	,	neglect will follow the protocol	for	DATE
		peratures. The group			Abuse and Neglect.	101	
	was provided information related to				/ loads and region.		
	· ·	peratures being					
	·	y and a repair company					
		o assess the problem.					
		nformation was					
	l •	sidents related to low					
		tures. On 8/21/13, the					
	group again was updated on the						
	current water temperatures and a possible resolution at the end of the						
	week.						
		rrent facility policy					
		"Residents Rights"					
	which was pro	<u> </u>					
	Administrator of	on 8/21/13 at 11:00					
	a.m., indicated	the following:					
		nts have the right to					
		cipate in a resident					
	council, to disc	•					
	grievances, fac						
	residents' right	S					
	D The Facility	, shall dayolar and					
	1	shall develop and					
		cies for investigation					
		g to complaints when					
		rievances made by:					
		idual resident;					
		ent council or family					
	council, or both	-					
	c. a family	-					
	d. family g	•					
	e. other in	dividuals.					

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PRINTED: 10/18/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 08/21/2013			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
VERMILL	ION PLACE		449 MAIN ST ANDERSON, IN 46016					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	This State Resi Complaint IN00 and IN0013483	idential tag relates to 0134810, IN00134755 36.						

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 6 of 14

PRINTED: 10/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
				LDING		08/21/	2013
			B. WIN			00/2 !!	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				449 MA			
	ION PLACE			ANDER	SON, IN 46016		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000090	410 IAC 16.2-5-1	.3(g)(1-6)					
	Administration an	id Management -					
	Deficiency						
		ator is responsible for the					
		ent of the facility. The					
		the administrator shall					
		ot limited to, the following:					
		division within twenty-four					
		oming aware of an unusual					
		lirectly threatens the					
	•	r health of a resident.					
	Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent						
	-	to the division within the					
	• , ,	nour time period. Unusual					
		ide, but are not limited to:					
	(A) epidemic outb	oreaks,					
	<ul><li>(B)poisonings;</li><li>(C) fires; or</li></ul>						
	(D) major accider	ato					
		not be reached, a call shall					
		mergency telephone					
	number published						
	•	nging for or assisting with					
		nedical, dental, podiatry, or					
		ther health care services as					
	-	resident or resident's legal					
	representative.	. se. ser i recidente logar					
	•	ector approval prior to the					
		ndividual under eighteen					
		to an adult facility.					
		acility maintains, on the					
		urate record of actual time					
	worked that indica						
	(A) employee's fu	ıll name; and					
		urs worked during the past					
	twelve (12) month	- · · · · · · · · · · · · · · · · · · ·					
	, ,	sults of the most recent					
		the facility conducted by					
	state surveyors, a	any plan of correction in					
	effect with respec	ct to the facility, and any					
		•					

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 7 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
MOLLAN	OI COMMETION	IDENTIFICATION NOWIDER.	A. BUILDING	<del></del>	08/21/2013	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	ROVIDER OR SUPPLIE	₹	449 M			
VERMILL	ION PLACE			RSON, IN 46016		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		eys. The results must be				
		mination in the facility in a				
	notice posted of	essible to residents and a				
		eports of surveys conducted				
		each facility for a period of				
		d making the reports				
		ection to any member of				
	the public upon r		DOOOOO	DOOD The advantage to the	10/11/2012	
		ervation, interview and	R000090	R090 The administrator did r think this situation required	not 10/11/2013	
	record review,			reporting. The water temps v	vere	
		ailed to report an		not fluctuating from under 100		
		rence related to varying		degrees to 140 degrees. The		
	•	tures from less than		temperature went to 140 on		
	100 degrees to	_		8/7/13. It was adjusted		
	•	cting 40 of 40 residents		immediately. After the adjustment, the water		
	who live in the	facility.		temperatures varied between	а	
				low of 95 to a high of 120		
	Findings include	de:		degrees. On the day of the		
				survey, one temp was reported		
	During a obser	vation on 8/21/13 at		86.9 degrees. The low water		
	2:20 p.m., the	Assistant Maintenance		temperatures continued until mixing valve was replaced an		
	Director was a	sked to check random		we were certain that the	lu	
	water tempera	tures in several rooms.		temperature would not go bac	ck to	
	Room 113 had	l a water temperature		140 degrees again. This was		
	of 96.4 degree	s, room 220 had a		assure that the residents' hea		
	water tempera	ture of 96.8 degrees		and safety was not in jeopard  Even though the low	y.	
	and room 229	<del>-</del>		temperature was not a health	or	
	temperature of	92.6 degrees.		safety issue, it was out of		
	·	-		compliance and should have		
	During an inter	view on 8/21/13 at		been reported as such to the		
	_	Administrator indicated		division. The administrator w review incidents in the future		
	·	p had been out for		this guideline in mind. Unusu		
		3 weeks and water		occurrences will be reported	iui	
		eached 140 degrees.		timely and according to state		
	•	no burns occurred as a		guidelines. The administrator		
		no samo occanca ao a		review this policy with the C.E	E.O.	

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 8 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED
			A. BUILDING		08/21/2013
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			
\/EDMILI	ION DI ACE			AIN ST	
VERIVIILI	LION PLACE		ANDE	RSON, IN 46016	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	result of the high	gh temperature. She		of United Faith Housing for	
	indicated the C	Corporation was notified		compliance. This will be	
		, but it was not reported		completed by 10/11/12	
	-	nent of Health as an			
	unusual occuri				
		CHOC.			
	Duning a manifest	of the water			
	During review				
	•	gs from 1/1/13-current,			
	-	4 rooms checked had			
	a water tempe	rature of 140 degrees.			
	A timeline sche	edule for the water			
	problem was p	provided by the			
	Administrator of	on 8/2/13 at 1:20 p.m.			
		ndicated on August 7th			
		mperatures reached			
		The water heater was			
	_				
		nd reported to the			
	head of mainte	enance.			
	On August 9th				
	company asse	ssed the problem and			
	indicated to pro	event the water from			
	getting too hot	, they needed to adjust			
	the "flaps."	,			
	On August 12t	h 2013, the CEO			
	contacted the				
		scuss the water			
	problem and s	olution.			
	During review	of the plumbing quote,			
	provided by the	e Administrator, the			
		dated 8/13/13 and			
		ost of the repairs. On			
		22. 2. a.o. opano. On			

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PRINTED: 10/18/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00		LETED 1/2013			
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP	CODE				
	LION PLACE		449 MAIN ST ANDERSON, IN 46016						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR 8/16/13, the CI of the estimate was written on following the in	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  EO agreed to the terms and a partial check 8/19/13, 12 days itial concern related to	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	the varying wa This State Res	ter temperatures. idential tag relates to 0134810, IN00134755							

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 10 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
			B. WIN			08/21/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			449 MA			
VERMILI	ION PLACE				RSON, IN 46016		
		TATEL OF DEPLOYED AND				1	(7/5)
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
R000187	410 IAC 16.2-5-1			TAG	Berielekery		DATE
K000101		andards - Deficiency					
		perature for all bathing and					
		cilities shall be controlled by					
	an automatic con						
		pint of use must be					
		een one hundred (100)					
		eit and one hundred twenty					
	(120) degrees Fa		DO(	0107			10/11/2013
	· · · · · · · · · · · · · · · · · · ·		R187 Residents C, D and E-T parts the facility were waiting f	R187 Residents C, D and E-The			
	•	•			arrived on August 27 and the h		
	maintain comfortable water temperatures between 100-120				water was fixed that day. Th		
					repair was completed for all		
	degrees, potentially affecting 40 of 40				residents of the facility. The		
	residents who live in the facility.				maintenance department will		
	(Residents # C	, D, and E)			monitor the water temps of the		
					building on a regular basis as of the preventive maintenance		
	Findings includ	le:	program. The Maintenance				
					Supervisor will monitor the		
	During the initia	al tour on 8/21/13 at			preventive maintenance progra	am	
	~	Assistant Maintenance			on an ongoing basis. Any time	9	
	•	sked to check random			the water temperatures go		
		tures in several rooms.			outside the state guidelines the		
		a water temperature			Maintenance Supervisor will b notified immediately. If the	е	
	of 86.9 degrees	•			problem is not rectified within a	a 1	
	or oo.a degrees	<b>5.</b>			hour period, the administrator		
	During an inter				C.E.O. will be notified.		
	~	view on 8/21/13 at					
	•	Administrator indicated					
		had been out for					
	• •	3 weeks and water					
	-	eached 140 degrees.					
	She indicated r	no burns occurred as a					
	result of the hig	gh temperature.					
	During review of	of the water					
	•	gs from 1/1/13-current,					
	•	<i>,</i>					

State Form Event ID: W8DI11 Facility ID: 011970 If continuation sheet Page 11 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		08/21/2013
		l .		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8	449 MA		
VFRMILI	ION PLACE			RSON, IN 46016	
				T	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
on 8/7/13, 4 of 4 rooms checked had					
	a water temper	rature of 140 degrees.			
	During an inter	view on 8/21/13 at			
	10:35 a.m., Re	sident #C indicated			
	there had beer	n no hot water going on			
		reeks. She indicated			
		aware of the concerns			
	,	ents and staff, but they			
		-			
were waiting on a part to come in to fix the problem. She indicated her					
	shower days were Monday and				
	•	<u> </u>			
	_	cause of the cold water,			
		en taking a shower,			
	_	p with heated water			
	from the micro	wave.			
	During an inter	view on 8/21/13 at			
	11:00 a.m., Re	sident #D indicated			
	she had been i	refusing showers			
	because of the	•			
		She indicated the			
		een going on for			
	approximately	-			
		nad been heating water			
		wave and using to			
	wash up.				
		of the hot water heater			
	room on 8/21/1	13 at 11:15 a.m., the			
	Assistant Main	tenance Director			
indicated the valves and spring on the mixing system were bad and in need of repair. The digital thermometer					
	•	e set at 98.4 degrees.			
	was noted to D	e set at 30.4 degrees.			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  00	COM	TE SURVEY MPLETED 21/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  449 MAIN ST  ANDERSON, IN 46016						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED TO	(X5) COMPLETION DATE				
	indicated the te set at 115 degree down to prever from filling into high of temperature. During an interpolar, Resident been taking conthe lack of hot she had also be the microwave. During a secont 8/21/13 at 2:20 Maintenance During a secont several rooms, water temperature temperature temperature. During the exituat 3:30 p.m., the Officer (CEO) is been ordered a should be fixed week.	view 8/21/13 at 2:00 #E indicated she had Id showers related to water. She indicated een heating water in to wash up with.  Ind observation on Ip.m., the Assistant Director was asked to water temperatures in Room 113 had a ture of 96.4 degrees, In water temperature of Ind room 229 had a ture of 92.6 degrees.  Indicated the parts had and the water problem If at the end of the Idential tag relates to 0134810, IN00134755							

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/21/2013			
NAME OF PROVIDER OR SUPPLIER  VERMILLION PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 449 MAIN ST ANDERSON, IN 46016				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	

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